GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 11, 2026

Gaven Bertram
Maple Specialized Residential Services
3060 S. Dye Rd.
Flint, MI 48507

RE: License #: AL250420040
Investigation #: 2026A0580031
Maple Specialized Residential

Dear Gaven Bertram:

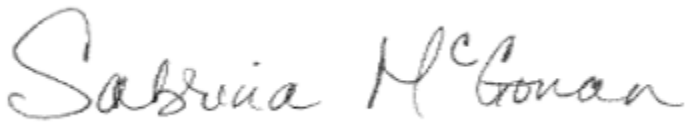
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,



Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AL250420040
Investigation #:	2026A0580031
Complaint Receipt Date:	05/11/2026
Investigation Initiation Date:	05/14/2026
Report Due Date:	07/10/2026
Licensee Name:	Maple Specialized Residential Services
Licensee Address:	3060 S. Dye Rd. Flint, MI 48507
Licensee Telephone #:	(833) 478-9464
Administrator:	Katrina Bailey
Licensee Designee:	Gaven Bertram
Name of Facility:	Maple Specialized Residential
Facility Address:	1132 East Maple Ave Flint, MI 48507
Facility Telephone #:	(810) 519-6433
Original Issuance Date:	12/29/2025
License Status:	TEMPORARY
Effective Date:	12/29/2025
Expiration Date:	06/28/2026
Capacity:	15
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A requires supervision while in the community and was not accompanied by staff to the hospital.	Yes
Resident A was pushed down by staff.	No

III. METHODOLOGY

05/11/2026	Special Investigation Intake 2026A0580031
05/11/2026	APS Referral Denied by APS for investigation.
05/14/2026	Special Investigation Initiated - On Site Unannounced onsite.
05/14/2026	Contact - Face to Face Interview with Resident B.
05/14/2026	Contact - Face to Face Interview with Resident C.
05/18/2026	Contact - Telephone call made Call to Raijon Fair, Home Mgr.
05/19/2026	Contact - Document Received Documents received.
06/01/2026	Contact - Telephone call made Call to Shelea Esset, Staff.
06/01/2026	Contact - Telephone call made Call to Kylie Feilds, Case Manager.
06/02/2026	Contact - Telephone call made Call to Nicole Kemp, Staff.
06/05/2026	Inspection Completed On-site Unannounced onsite. Interview with Resident A.
06/05/2026	Contact - Telephone call made

	Call to Kylie Fields, Case Mgr.
06/05/2026	Contact - Document Received Hospital Discharge Summary for Resident A.
06/11/2026	Exit Conference An Exit Conference was conducted with Admin Bailey.

ALLEGATION:

Resident A requires supervision while in the community and was not accompanied by staff to the hospital.

INVESTIGATION:

On 05/11/2026, I received a complaint via LARA-BCHS-Complaints. This complaint was denied by Adult Protective Services (APS) for investigation.

On 05/14/2026, I conducted an unannounced onsite inspection at Maple Specialized Residential AFC home. Contact was made with Direct Staff (DS), Andrea Fields. DS Fields had no knowledge of Resident A going to the hospital unaccompanied. Resident A is currently away from the home, on an outing with staff.

While onsite I observed 3 residents in the home. 1 resident was sitting in the dining room area, 1 resident was observed while in his room, and another resident was observed outside. These residents were all adequately clothed and groomed. No concerns regarding their care were noted.

On 05/18/2026, I interviewed Raijon Fair, Home Manager (HM) at Maple Specialized Residential. HM Fair stated that Resident A calls 911 daily, which is part of his baseline behaviors. Manager Fair stated that on the day in question Patriot EMT staff talked to Resident A outside in an effort to talk to him away from staff, so staff went inside. The EMTs then took Resident A to the hospital without staff knowledge. Upon noticing that Resident A was gone, staff contacted Patriot EMS, who denied that he was transported in their care. HM Fair then contacted 911 and made a missing person's report. Later it was discovered that Patriot EMS did in fact transport Resident A to the hospital.

On 05/19/2026, I received a copy of the documents requested. The incident report dated 05/11/2026 states that upon his return to the home after eloping, consumer repeatedly called 911. Resident A was transported to Hurley Hospital then discharged hours later. Staff attempted verbal redirection while consumer was having a challenging behavior. All attempts failed. Staff will continue to monitor for health and safety.

The AFC Assessment Plan for Resident A was also received. The plan indicates that staff should accompany Resident A while out in the community.

On 06/01/2026, I placed a call to Kylie Fields, Case Manager at Northern Great Lakes Community Mental Health (CMH), assigned to Resident A. There was no answer. A voice mail message was left requesting a return call.

On 06/01/2026, I interviewed DS Shelea Essett. DS Essett recalled that both the police and the EMS were at the home due to Resident A's constant calls to 911. The police took Resident A outside to talk. While inside, staff checked and observed Resident A, EMS and police still outside. Upon preparing to take a different resident outdoors, staff noticed that everyone was gone. Staff assumed that Resident A eloped because neither the police nor EMS informed staff that they were taking Resident A away.

On 06/02/2026, I interviewed DS Nicole Kemp. DS Kemp recalled that Resident A kept calling 911. On the second visit to the home the police inquired why Resident A called and he stated that his back was hurt. The police then indicated that they'd contacted EMS and took Resident A outside. Staff looked outside and they were still on the porch. Upon looking again, everyone was gone. Staff Essett then contacted HM Fair. It is her understanding that HM Fair contacted the police department, who stated that Resident A was not in their care. Staff assumed Resident A had eloped. Staff Kemp stated that it was eventually discovered that Resident A was at the hospital.

On 06/05/2026, I conducted a follow-up unannounced onsite inspection at Maple Specialized Residential Home. An interview was conducted with Resident A while in his room. Resident A stated that while outside talking to the police, the police called the ambulance. The ambulance then took Resident A to the hospital. Resident A stated that the staff all thought he was missing because neither the police nor the ambulance told the staff that they were taking him to the hospital. I observed Resident A as being adequately dressed and groomed. No concerns regarding his care were noted.

While onsite I observed 4 residents all sitting in the living room area along with the HM Fair and 1 additional staff. The residents were observed as being adequately dressed and groomed. No concerns regarding their care were noted. HM Fair provided a copy of the additional documentation requested.

On 06/05/2026, I received a copy of the Hurley Hospital Discharge Summary for Resident A. The summary dated 05/11/2026 indicates that Resident A was seen for back pain and diagnosed with back strain. Resident A was advised to take Tylenol or ibuprofen as needed. Resident A returned to the AFC that same evening.

On 06/05/2026, I interviewed CM Kylie Fields. CM Fields stated that Resident A is a frequent 911 caller. The police have previously come out in the past and taken Resident A to the hospital without staff knowledge. CM Fields had no knowledge regarding this incident due to not being informed.

On 06/11/2026, I interviewed Administrator, Katrina Bailey. Administrator Bailey stated that it is her understanding that staff did request that the police notify staff if they were taking him away. Staff also conducted the required 15-minute check on the resident while outside, when they noticed that he was missing. Administrator Bailey has also spoken with Resident A's assigned case manager regarding possible phone restrictions to cut down on the phone calls to 911.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	It was alleged that Resident A requires supervision while in the community and was not accompanied by staff to the hospital. Direct Staff, Andrea Fields, had no knowledge of Resident A going to the hospital unaccompanied. Home Manager, Raijon Fair, stated that on the day in question Patriot EMT staff talked to Resident A outside in an effort to talk to him away from staff, so staff went inside. The EMTs then took Resident A to the hospital without staff knowledge. Upon noticing that Resident A was gone, staff contacted Patriot EMS, who denied that he was transported in their care. HM Fair then contacted 911 and made a missing person's report. Later it was discovered that Patriot EMS did in fact transport Resident A to the hospital. The incident report dated 05/11/2026 states that upon his return to the home after eloping, consumer repeatedly called 911. Resident A was transported to Hurley Hospital then discharged hours later. Staff attempted verbal redirection while consumer was having a challenging behavior. All attempts failed. Staff will continue to monitor for health and safety. The AFC Assessment Plan for Resident was also received. The plan indicates that staff should accompany Resident A while out in the community.

	Direct Staff, Shelea Essett, recalls that both the police and the EMS were at the home due to Resident A's constant calls to 911. The police took Resident A outside to talk. While inside, staff checked and observed Resident A, EMS and police still outside. Upon preparing to take a different resident outdoors, staff noticed that everyone was gone. Direct Staff, Nicole Kemp, recalls that Resident A kept calling 911. On the second visit to the home the police inquired why Resident A called and he stated that his back was hurt. The police then indicated that they'd contacted EMS and took Resident A outside. Staff looked outside and they were still on the porch. Upon looking again, everyone was gone. Resident A stated that while outside talking to the police, the police called the ambulance. The ambulance then took Resident A to the hospital. Resident A stated that the staff all thought he was missing because neither the police nor the ambulance told the staff that they were taking him to the hospital. The Hurley Hospital Discharge Summary for Resident A dated 05/11/2026, indicates that Resident A was seen for back pain and diagnosed with back strain. Resident A was advised to take Tylenol or ibuprofen as needed. Resident A returned to the AFC that same evening. Case Manager Kylie Fields stated that she had no knowledge regarding this incident due to not being informed. Resident A is a frequent 911 caller. The police have previously come out in the past and taken Resident A to the hospital without staff knowledge. Based upon my investigation, which consisted of interviews with multiple facility staff members and residents, as well as a review of relevant facility documents pertinent to the allegation, there is enough evidence to substantiate the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was pushed down by staff.

INVESTIGATION:

On 05/14/2026, DS Fields stated that Resident A has not expressed to her that he was pushed down by a staff member. DS Fields denied that she pushed Resident A down, causing back pain.

On 05/14/2026 while onsite, I interviewed Resident B. Resident B was interviewed and observed while in his bedroom. Resident B denied any mistreatment from staff in the home. Resident B was adequately clothed and groomed. No concerns regarding his care were noted.

On 05/14/2026, while onsite, I attempted to interview Resident C. Upon entering Resident C's room, Resident C was observed outside at his bedroom window. The window was open and screened. When asked if he had experienced mistreatment from any staff in the home, Resident A looked at me, rolled his eyes and continued to smoke his cigarette. Resident C did not answer the question. Resident C was adequately groomed and dressed appropriately for the weather. No concerns regarding his care were noted.

On 05/18/2026, HM Fair denied any knowledge that Resident A was pushed down by a staff member. Resident A did not inform him that a staff member pushed him down. Manager Fair denied that he pushed Resident A down, causing back pain.

On 06/01/2026, DS Essett denied that she pushed Resident A down. DS Essett denied Resident A has ever expressed that he was pushed down by a staff.

On 06/02/2026, DS Kemp denied that she pushed Resident A down. DS Kemp denied Resident A has ever expressed that he was pushed down by a staff.

On 06/05/2026, Resident A stated that he called 911 because his back was hurting due to being pushed down by staff. Resident A does not know the staff's name and can only identify her as a black female. Resident A did not report the female staff to HM Fair or any other staff. Resident A denied that there were any witnesses to this incident. Resident A stated otherwise, he is treated pretty fair in the home. Resident A stated that he had no current complaints or concerns.

On 06/05/2026, I interviewed CM Kylie Fields. CM Fields stated that she had no knowledge of the allegations that staff pushed Resident A down, causing back pain. CM Fields stated that she visits with Resident A monthly in the home. CM Fields expressed that while the home is not perfect, she has seen no red flags or previous concerns regarding Resident A's care or staff mistreatment.

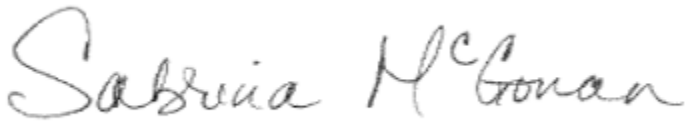
On 06/11/2026, I interviewed Administrator, Katrina Bailey. Administrator Bailey was not aware there was an allegation that Resident A was pushed down by staff. An exit

conference was conducted with Administrator Bailey. Administrator Bailey was informed of the findings of this investigation.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	It was alleged that Resident A was pushed down by staff. Home Manager, Raijon Fair and Direct Staff members, Andrea Fields, Shelea Essett, and Nicole Kemp all denied the allegation that staff pushed Resident A down, causing back pain. Resident A stated that he called 911 because his back was hurting due to being pushed down by staff. Resident A does not know the staff's name and can only identify her as a black female. Resident B denied any mistreatment from staff in the home. Resident C did not respond when interviewed regarding the allegations. Case Manager, Kylie Fields. CM Fields stated that she had no knowledge of the allegations that staff pushed Resident A down, causing back pain. CM Fields expressed that while the home is not perfect, she has seen no red flags or previous concerns regarding Resident A's care or staff mistreatment. Based upon my investigation, which consisted of interviews with multiple facility staff members and residents, as well as a review of relevant facility documents pertinent to the allegation, there is not enough evidence to substantiate the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

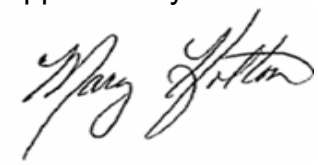
Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.



June 11, 2026

Sabrina McGowan — Date
Licensing Consultant

Approved By:



June 11, 2026

Mary E. Holton — Date
Area Manager